Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Public Report

Report Issue Date: July 16, 2025
Inspection Number: 2025-1559-0005
Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Regional Municipality of Durham
Long Term Care Home and City: Hillsdale Estates, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8-11, 14-16 2025.

The following intake(s) were inspected:

Intakes related to neglect

Intake related to elopement.

Intake First Follow-up #: 1 -Compliance Order (CO) #001 / from inspection 2025-1559-0004, O. Reg. 246/22 - s. 79 (1) 4. Dining and snack service, with a compliance due date (CDD) of July 2, 2025.

Intake related to abuse.

Intake related to a complaint regarding medications.

Intake related to complaint concerns regarding falls and neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1559-0004 related to O. Reg. 246/22, s. 79 (1) 4.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: RIGHT TO FREEDOM FROM ABUSE AND NEGLECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure that resident #008's rights to freedom from abuse are fully respected and promoted.

An altercation occurred between resident #009 and resident #008 that resulted in an altercation. Resident #009 became physically aggressive, causing injury to resident #008.

Source: Resident #008's clinical record, interview with Resident Care Coordinator (RCC) #113.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee failed to protect resident's right to be free from neglect when PSW #101 removed the fall prevention intervention and did not monitor the resident for an extended period.

Ontario Regulation 246/22, s. 7, defines “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The resident fell and sustained an injury and was found by staff after a period of time. Personal Support Worker (PSW) #101 removed the falls prevention intervention for resident #001 and did not check on the resident afterward, leading to a prolonged monitoring lapse, delayed fall detection, and the resident being injured and left unattended until staff from the next shift found them.

Source: Resident's clinical records, Home's investigation records, Interviews with PSW #101 and RCC #110

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care outlined in the resident's plan of care was provided to the resident as specified in the plan.

The resident had a fall and sustained an injury. Personal Support Worker (PSW) #101 provided assistance to a resident in bed, during which PSW #101 removed the falls prevention intervention and left the resident's room. According to the resident's care plan, the falls prevention intervention is to remain applied while resident is in bed.

Source: Resident #001's clinical records, interview with PSW #101

WRITTEN NOTIFICATION: Dining and snack service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The licensee has failed to ensure the dining service provides monitoring to a resident during mealtime.

PSW #118 delivered the meal tray to a resident's room and left the resident unsupervised, which resulted in an incident. The resident was hospitalized and later returned home with an diagnosis post incident. An observation was conducted on a later date, where PSW #114 delivered a meal tray to the resident's room and left the resident unsupervised. Resident's care plan requires specific interventions during meals, which were not followed.

Source: Observation, interview with PSW #114, Resident's clinical records.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that no drug is administered to a resident, unless the drug has been prescribed for the resident. The resident was not prescribed a medication that was administered to them.

Sources: Resident records, Medication Incident report #MIR-61618, and interview with RCC #113.